GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Administrative Issuance: CFSA-06-8

To: All CFSA Staff

From: Audrey Sutton, Deputy Director for Programs

Date: April 19, 2006

Re: Protocols for the Referral of Low to Moderate Risk Families to the Collaboratives

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Research has determined that children's protective services should serve high and intensive risk families to prevent recurrence of maltreatment, subsequent injury and/or removal of the child from home. For low and moderate risk cases, using children's protective services does not significantly affect the rate of recurrence of maltreatment, subsequent injury or removal. Therefore, low and moderate risk cases are referred to other community-based services so that children's protective services' resources can continue to be strategically directed toward serving and impacting the needs of high and intensive risk cases.

This administrative issuance provides guidance to CFSA staff regarding the criteria and process for referral of low and moderate risk families to the Collaboratives. If you have any questions regarding this administrative issuance, please contact the Deputy Director for Programs.

Criteria

The following criteria must be met prior to referral of a family to the Collaboratives from the CPS Administration:

1. Completed investigation;
2. All children remain in the home;
3. No Court involvement;
4. Initial risk assessment scores the family as low or moderate risk; and
5. Family/parent must agree to services and have signed an Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative form (attached).

The following criteria must be met prior to referral of a family to the Collaboratives from any ongoing services administration:

1. All children remain in the home;
2. No Court involvement;
3. Case has been open at least 90 days;
4. Risk reassessment scores the family as low or moderate risk at the time of referral; and
5. Family/parent must agree to services and have signed an Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative form.

Referral Process

1. For completed investigations and active cases that meet the criteria listed above, the social worker shall assist the family in completing the Authorization to Refer and Disclose Information to Healthy Families Thriving Communities Collaboratives. The completed referral shall be submitted to the supervisor for review and approval.
2. Upon supervisory review and approval, the social worker shall submit the referral to the Collaborative Liaison's office.
3. The Collaborative Liaison shall review the referral for completeness and appropriateness.
4. For referrals that are determined not to be appropriate, the Collaborative Liaison shall meet with the referring social worker and supervisor to obtain more information or to guide them to internal resources.
5. For referrals determined to be appropriate, the Collaborative Liaison shall convene a gatekeeping committee to review the referrals for assignment.
6. The gatekeeping committee shall meet three (3) times weekly and be comprised of the following persons:
    a. Collaborative Liaison or designee;
    b. Two (2) CPS representatives, one (1) program manager and one (1) supervisor, on a rotating basis; and
    c. Two (2) Collaborative representatives, on a rotating basis.
7. The Collaborative Liaison shall approve and send the referrals to the appropriate Collaborative.
8. The Collaborative Liaison shall coordinate a staffing between the referring social worker and the collaborative worker to discuss the issues and needed services for the family.
9. The Collaborative Liaison shall track the referrals and notify the social worker of the referral status.
10. If a family refuses services from the Collaborative, the referral shall be returned to the gatekeeping committee for a decision to close the case or open the case to CFSA.

Note: The decision to open or close a CFSA or court case is solely that of CFSA and the Office of Attorney General.

11. The social worker shall document the status of the referral on the Contacts screen in FACES.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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Authorization to Refer and Disclose Information to Healthy Families/Thriving Communities Collaboratives

Si usted no entiende el idioma Inglés, favor de pedir esta forma en Español.

Instructions

- The "Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative" (Authorization) is used by Child and Family Services Agency (CFSA) staff to authorize the referral of a client to a Healthy Families Thriving Community Collaborative (Collaborative) for services. It also permits CFSA to provide non-health related information about the client to the Collaborative.

- The Authorization may be signed by an individual who is referred for individual services (for example, a former foster child who aged out of foster care) or by a parent or guardian on behalf of herself/himself and the minor children. If there are questions about who can sign, contact the Office of General Counsel.

- If medical or dental information also needs to be sent to the Collaborative, use the "Authorization to Disclose Medical or Dental Information" to permit that disclosure. Similarly, if mental health or substance abuse information also needs to be sent to the Collaborative, use the "Authorization to Disclose Mental Health and Substance Abuse Information".

- If the client is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization.

- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, as long as the client signs or marks the Authorization.

- The Authorization must be witnessed by the CFSA social worker.

- When the case is sent to the Collaborative, the signed and witnessed Authorization should be sent along with the completed "Case Referral Form to the Collaborative".

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Authorization to Refer and Disclose Information to Healthy Families/Thriving Communities Collaboratives

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See Attached Instructions

I. Referral to Collaborative

1. I, _____, hereby authorize the Child and Family Services Agency (CFSA) to refer
Name of Individual, Parent or Guardian
the individuals named below to the _____ Collaborative (Collaborative).
Name of Collaborative

2. The purpose of the referral is: _____
_____
_____
_____.

II. Individual(s) being Referred *If additional individuals are being referred, please identify them on Attachment A. This includes identifying the spouse/significant other and all children in the family who are being referred.*

1. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

III. Information to be Released *Use additional pages if necessary.*

1. To enable the Collaborative to serve me/us, I further authorize CFSA to disclose information to the Collaborative as follows: _____
_____
_____
_____
_____.

IV. Signature

- I understand that this Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative (Authorization) permits the release of both oral information and documents.
- I understand that the information used or disclosed on the basis of this Authorization may not be disclosed again by the recipient except by my express authorization or otherwise in accordance with applicable law.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency
attn: _____, Social Worker
400 6th Street S.W.
Washington, DC 20024

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reliance of this Authorization before it received written notice of my revocation.
- I understand that this Authorization will expire six (6) months from the date on which I sign it, and that I may sign a new Authorization for an additional six (6) month period.
- I have received a copy of this Authorization.

_____ _____
Individual's Signature *Date*

_____
Name printed

Address: _____

Telephone Number: _____

Relationship to persons named in Part II: Parent Legal guardian Self (if over 18 years of age) *Note: if not the parent, legal guardian or self (and over 18 years of age), discuss with Office of the General Counsel*

Witness: _____
Social Worker's Signature

_____
Social Worker's Name Printed

Attachment A: Individual(s) being Referred Continuation Sheet
Authorization to Refer and Disclose Information to Health Families Thriving Community Collaborative

II. Individual(s) being Referred *If additional individuals are being referred, please identify them on Attachment A. Use as many sheets as needed.*

2. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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3. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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4. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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5. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____